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DECEMBER 1969

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THE HAMPDEN HIPPOCRAT

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EDITORIAL

MORAL PROBLEMS FACING MEDICINE

Current technical medical advances are bringing about a variety of situations in medical practice demanding decisions in the face of acute moral dilemmas. Specifically, the following raise grave moral questions:

(1) Organ transplantation (including the use of organ and tissue banks as well as artificial organs), wherein there are conflicting ethical principles motivating recipients, donors, respective families, health professionals, and the public;

(2) Hemodialysis, wherein conflict between individual and community desires and responsibilities are fanned by economic factors;

(3) Genetic control through gene manipulation, which is still experimental but portends frightening future potentialities;

(4) Artificial insemination, wherein many legal difficulties arise involving questions of illegitimacy, inheritance rights, and family relationship;

(5) Environmental alterations by a variety of polluting practices thereby depriving ourselves and our descendants of a safe world;

(6) Development of new chemical agents designed for use as antibiotics, contraceptives, growth regulators, anticarcinogens, mood and behavior modifiers, etc., wherein moral issues involving human experimentation and purposes of ultimate use are raised.

Moreover, let us not forget such basic moral questions, which have been with us since time immemorial, as abortion, fertility control, and euthanasia.

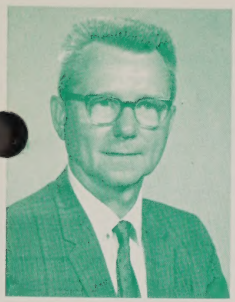
ETHICS

The moral aspects associated with current technical medical advances involve ethical theory, and there are many conflicting points of view raised by various ethical theories. To quote Dr. Chauncey D. Leake, writing in the May 5, 1969 issue of JAMA: "There are several important ethical theories regarding human purposes, motivations, and conduct. They range from rather selfish hedonism to altruistic social idealism, from harmonious adaptation to environments to self-conscious and adjustable individualism, and from utilitarianism to pragmaticism, and with the probability of a naturally operating principle which derives from biologically built-in neural mechanisms associated with adaptive and survival factors."

QUESTIONS LOOKING FOR ANSWERS

In the light of the aforesaid, there are many questions about medical morals and ethics demanding answers to current and foreseeable problems facing and affecting the practicing physician. How can these various issues be best brought to the surface, faced, and hopefully resolved? Certainly a comprehensive and cooperative inquiry into the problems of medical morals and ethics is long overdue. Perhaps, there is need of a center for the study of medical morals and ethics; greater involvement of philosophers, clergymen, physicians, lawyers, sociologists, psychologists, engineers, as well as political scientists and others from various walks and sophistications of life; and greater support as well as participation by universities, foundations, professions, and corporations whose activities are related to medicine. Much has been done, much is being done, but the subject demands much more, particularly when allocation of resources is taken into consideration. A greater investment may veritably pay a high dividend in terms of greater wisdom in keeping up with ever advancing medical technology.

Ayres



PRESIDENT'S PAGE

LOVE IS ETERNAL

Medicine and religion have been inseparable since the dawn of homo sapiens. One is impossible without the other; just as life certainly is but the pathway leading to death.

Modern society is again reading quotations questioning the existence of God. Belief in religious tradition is once more being discussed, criticized, and all too often, abandoned. But this is no new practice, as we all know. It has happened before. History is replete with instances of similar periods of national questioning and with individual instances of a faith being discarded, only to be regained later.

Literature reveals many fascinating life histories describing this tidal behavior of man's intellect. Strangely enough, even Russian literature contains interesting examples which can be applied to our world today. One of these is the story of Fyodor Dostoevsky (1821-1881), who, as a student, lost his faith at 16 years of age. He subsequently, because of his revolutionary activities, spent several years in a Siberian prison, where he suffered impossible conditions of hardship and torture. He later wrote of these experiences and some of his thoughts I would like to quote: "Man must have a God; if he denies the true God, he makes himself a god. Once a man makes himself a god, then all things are allowable. Man can become a demon by the abuse of free will, and man can become evil by simply denying the distinction between good and evil."

Our affluence is receiving credit for much of the moral decadence in existence today even though poverty appears to remain unabated in our society. The adult world is critical of the younger generation's interest in sex, drugs, and outlandish hair and clothing; yet, a review of the adult establishment reveals that Kinsey's figures on extra-marital sexual excesses among our suburban fathers and mothers may have been considerably conservative. Statistics on alcoholism and suburban cocktail parties reveals a constantly upward curve of tragedy, illness and death. Finally, figures on costs of cosmetics, fur wraps, and hair dressing leads to an astronomical amount of billions of dollars that can hardly be expected to develop affection between the poor and their affluent neighbors.

Let us be frank! This is truly an age of hypocrisy! Our religious comrades face a difficult struggle. They deserve our respect.

May I close by quoting a proverb so familiar to our Jewish colleagues: "What does it profit a man if he gain the whole world and lose his own soul."

Walter S. Mozden, M.D.

MEDICINE AND RELIGION

By

GARRY deN. HOUGH, III, M.D.

CHAIRMAN, MMS COMMITTEE ON MEDICINE AND RELIGION

In the JAMA, August 11, 1969, Dr. Richard Parlour of Claremont, California, wrote "Few things are as damaging to a reputation as pretending to be expert in areas where one is clearly not. The medical profession adds tarnish to its public image when it invades the sphere of morality."

On July 13, 1969, at the Medico-Religious Symposium at the annual meeting of the AMA, Mr. Brenton Sexton, an ex-drug addict, said "It is absolutely essential that the entire society learns or relearns to interact with each other as human beings."

It is the function of a group concerned with medicine and religion to promote cooperation between physicians and clergy for the better care for the patient. This requires the medical expert to leave his unassailable castle of professional competence and to go abroad in the market place of societal need. The Committee of Medicine and Religion of the MMS has succeeded in organizing district committees in 18 of 21 districts and serves as liaison between the AMA and these committees. The Hampden District Committee antedated the MMS Committee and has been one of the three most active district committees in the State.

The MMS Committee organized a panel on the "Artificial Prolongation of Life" at the 1968 meeting of the MMS and an exhibit on drug abuse at the 1969 meeting. Other state activities include educational workshops for District Medico-Religious Committee chairmen and distributions of bibliographic material on social illnesses. The work of the Committee is hampered by the fact that most interested physicians are already extremely active in combatting socio-medical problems under other auspices. This may include sex education, ethical guidelines for organ transplantation, or clinical pastoral training for theological students. In any case, the goals of the program are being met, but little time is left for committee work to plan coordination and new programs.

The MMS Committee on Medicine and Religion intends to stimulate more physicians to look beyond their role as medical experts in a limited field. Our patients need more than expert attention to their peptic ulcer, enlarged prostate, or broken limbs. Physicians must concern themselves with the whole patient and with the society from which he comes. Our particular training and discipline gives us a point of view which is valuable to the whole society, even in fields where we are only a relative "expert." To expand this point of view will not tarnish our reputation but will restore respect as citizens concerned for our fellow men, instead of for a "fast buck."

Involvement of this sort turns out to be a two-way street. Not only do we enhance our public image, but we also learn more about our patients and their needs. At the same time that we are helping society, we are helping ourselves become more effective physicians. You don't believe me? Try it!

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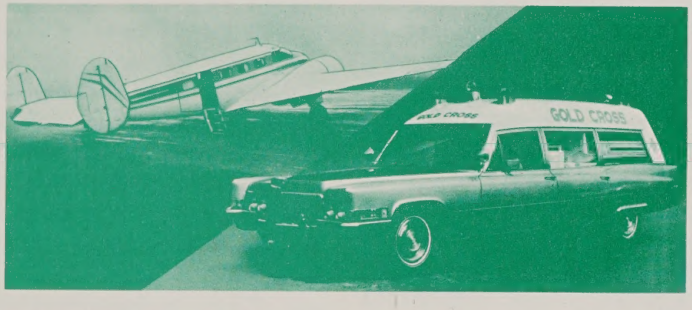

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ONE MAN'S OPINION . . .

THE DIAGNOSIS OF DEATH

"The worst thing about death," someone once quipped, "is that it is so absolutely final." But when is death absolutely and irreversibly final? Is it when the heart has stopped beating or the lungs—breathing? Is it when the E.E.G. has become isoelectric, or is it when all the cellular elements of the human body have ceased functioning?

Fear of premature burial was the chief concern of our ancestors. Reports of such burials, some of them fairly well documented, appeared in the literature prior to the 20th century (JAMA, Nov. 25, 1968). During the early part of this century diagnostic improvements and the introduction of embalming have served to diminish the danger of premature burial. The recent advent of cardiac transplants has given the diagnosis of death a completely new dimension. For obvious reasons the donor's death has to be determined not only accurately but also promptly. This is no simple task especially now when life can be sustained by supportive procedures long after pulmonary and perhaps even cardiac failure occurs.

THE DEFINITION OF DEATH

It seems strange that at this late date we should still be groping for a true definition of death. The problem has become complicated of late with the discovery that death is not the sudden, abrupt, and instantaneous cessation of life we used to believe it to be, but rather a gradual process at the cellular level. Some tissues simply survive the deprivation of oxygen longer than others. Based on this newer knowledge a number of more meaningful definitions of death have been suggested during the last year or two. One example is a statement submitted by the Medical Ethics Committee of the World Medical Association during its 22nd Assembly held in Sydney, Australia in August of 1968.

The statement, known as "The Declaration of Sydney" follows:

"The determination of the time of death is in most countries the legal responsibility of the physician and should remain so. Usually he will be able without special assistance to decide that a person is dead, employing the classical criteria known to all physicians.

"Two modern practices in medicine, however, have made it necessary to study the question of the time of death further: (1) the ability to maintain by artificial means the circulation of oxygenated blood through tissues of the body which may have been irreversibly injured and (2) the use of cadaver organs such as heart or kidneys for transplantation.

"A complication is that death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells but in the fate of a person. Here the point of death of the different cells and or-

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gans is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation may be employed.

"This determination will be based on clinical judgment supplemented if necessary by a number of diagnostic aids of which the electroencephalograph is currently the most helpful. However no single technological criterion is entirely satisfactory in the present state of medicine nor can any one technological procedure be substituted for the overall judgment of the physician. If transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be immediately concerned with the performance of the transplantation."

The assembly adopted the declaration and approved a committee plan to continue its studies toward an exact definition.

Another definition of death, this one labelled "Characteristics of Irreversible Coma," is contained in a report of the Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death (JAMA 205: 337-340, August 5, 1968).

CHARACTERISTICS OF IRREVERSIBLE COMA

"An organ, brain, or other, that no longer functions and has no possibility of functioning again is for all practical purposes dead. The condition can be satisfactorily diagnosed by points 1, 2, and 3 to follow.

"1. *Unreceptivity and Unresponsitivity.*—There is a total unawareness to externally applied stimuli and inner need and complete unresponsiveness.

"2. *No Movements or Breathing.*—Observations covering a period of at least one hour by physicians

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is adequate to satisfy the criteria of no spontaneous muscular movements or spontaneous respiration or response to stimuli such as pain, touch, sound, or light.

"3. *No Reflexes.*—Irreversible coma with abolition of central nervous system activity is evidenced in part by the absence of elicitable reflexes. The pupil will be fixed and dilated and will not respond to a direct source of bright light. Ocular movement and blinking are absent. There is no evidence of postural activity (decerebrate or other). Swallowing, yawning, vocalization are in abeyance. Corneal and pharyngeal reflexes are absent. As a rule the stretch of tendon reflexes cannot be elicited.

"4. *Flat Electroencephalogram.* —Of great confirmatory value is the flat or isoelectric EEG."

A Committee on Ethics of the American Heart Association recommended that the above be accepted as evidence of brain death.

ETHICAL GUIDELINES AND MEDICAL PROGRESS

One of the unexpected benefits of cardiac transplants is the attention it focused on the long-neglected subject of death. No one is legally dead unless pronounced so by a physician, yet the medical school curriculum, even today, offers practically no instruction in the recognition of this the most critical of all stages of human life. Most of us in Hampden will probably never be called upon to evaluate the life-or-death status of a prospective organ-donor. Nevertheless, the documents cited above are bound to add substantially to our understanding of the definition and diagnosis of death. Moreover, these documents served to demonstrate again the readiness of our profession to formulate ethical guidelines for whatever new clinical situations may develop or arise.

It is interesting to note that until 1947 our ethical conduct was guided almost entirely by the Oath of Hippocrates and the Codes of Ethics of our parent organizations. Since then, however, a number of guidelines, applicable to special situations, have been adopted. Thus, in 1947, The Nuremberg Code (a guide in carrying out experiments on human subjects), was propounded and in 1948 the Declaration of Geneva (a modified form of The Hippocratic Oath), was adopted by The World Medical Association. Then came The Declaration of Helsinki (1964); The AMA Ethical Guidelines for Clinical Investigation (1966); and the Supervision of Experimental Subjects as Recommended by The Royal College of Physicians (1967). The texts of these documents have been published at various times in the pages of *The Hippocrat.*

It should be emphasized that all the newer guidelines conform to concepts already embodied in the AMA's Principles of Medical Ethics. Nevertheless, these documents and declarations serve a very useful purpose, spelling out as they do our ethical responsibilities in specific or definitive circumstances. It is safe to assume that with the progress of medicine more and more clinical situations will arise requiring additional guidelines for the conduct of our profession.

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MALPRACTICE

A GROWING PROBLEM FOR PHYSICIANS

At least one physician in five will be sued for malpractice before the end of his career if the present growth of claims continues. Richard P. Bergen, AMA Legal Research Director, says 7,000-10,000 claims are filed annually, and other estimates run even higher. Obviously, the risk is not evenly spread, with certain high risk specialties of orthopedics, neurosurgery, anesthesiology and plastic surgery being most vulnerable. Nevertheless, the alarming growth of malpractice suits is of serious concern to all doctors.

Not only is the number of suits rapidly increasing, but the size of the verdicts awarded by juries is growing tremendously. The highest award in Massachusetts is $416,000 and the record for the country as a whole stands at 1.5 million dollars, a case recently upheld by a Florida appeals court. The trend appears to be nationwide with no relief in sight.

RATES

As one would expect, this trend is reflected in ever-increasing insurance rates. The sharp increase in insurance premiums throughout the country may be due in part to inflation, but the increases in the number of suits and in the size of the settlements and judgments are certainly major factors. The Insurance Information Institute of New York reports that malpractice rates are now 47% above the rates of a year ago. In some areas, as in Vermont, the increase is over 100%, and in Michigan, where general practitioners have had a 50% increase, cer-

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tain specialists have suffered increases as high as 300%. In Massachusetts, general practitioners who do surgery pay $436 for $100,000/$300,000 coverage as compared to $227 in 1967, an increase of nearly 100%. The Committee on Professional Liability of the MMS reports that the premium for Class V surgeons in Massachusetts with single coverage for basic limits ($5,000/$15,000) was $240, compared to Mississippi with the lowest rate of $115 and California with the highest rate of $925. For $100,000/$300,000 coverage in California, the rate for internists is $879 and for surgeons the rate including the million dollar "umbrella" coverage may run as high as $4,286.

Yet, in spite of these huge increases in premium rates, insurance companies want to get out of the malpractice field. The World Medical News reports that pay-outs including claim payments, projected losses and defense costs tower 55% above premiums, and insurance companies feel that even with the large rate increases, malpractice insurance is a losing proposition. At one time, California had nine companies writing malpractice insurance, and now there are only two such companies. Aetna Life and Casualty Company of Hartford, Connecticut, one of the giants in the field, has all but stopped writing new policies and is very selective in renewing old ones. For the year 1968, Aetna reports a loss of $10,000,000 in malpractice insurance. With insurance companies finding the business unprofitable, and many of them dropping from the field entirely, many physicians are being left with no insurance at all. Says Mr. Bergen, AMA Legal Research Director: "My advice to doctors these days is pay what you have to to get adequate coverage. This is no time to be shopping around for malpractice insurance on the basis of price alone." For members of the HDMS, the Members' Insurance Committee advises adding our group "umbrella" policy to their standard coverage.

CAUSES

What is the cause of the continuing growth of suits? The Committee on Professional Liability of the MMS cautions that "many if not most suits are initiated by one MD's criticism of a colleague and loose talk." Furthermore, law suits have been encouraged by other factors. The previous requirement that medical witnesses in malpractice suits be practicing in the same locality as the defendant has been abolished by judicial decisions in many areas. Such a decision was made

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in Massachusetts in the past year. Furthermore, the legal doctrine "res ipsa loquitur" (the thing speaks for itself) has favored the plaintiff and may very well have encouraged suits that might not have been filed otherwise. Under this doctrine it is not necessary to produce a medical witness to prove a certain point. This doctrine has already been eliminated in Alaska.

Lawyers' contingency fees generally amount to one-third or one-half of any verdict or settlement, and while this fact is never mentioned in court, it is well known and may influence the size of the award by juries. Efforts to abolish contingency fees have been resisted by the lawyers. They argue that contingency fees have been standard practice in all tort cases for many years, and are necessary to give the poor man his day in court. Few clients are willing to pay lawyers a per diem fee for the time involved in preparing and trying a case in which he may lose and get nothing. Instead, the lawyer takes the gamble via the contingency fee.

SOLUTIONS

What can be done about all of this? The AMA's House of Delegates in July, 1969 voted that constituent associations "seek the enactment of appropriate state legislation designed to provide a more efficient and equitable determination of malpractice claims and litigation." The House, furthermore, voted to "seek the cooperation of hospital associations and third party payers in exploring and developing, if feasible, pilot programs which will provide scheduled benefits for persons injured as a consequence of medical accidents occurring during the delivery of health care, irrespective of fault." Such a plan would be comparable to Workmen's Compensation and would provide for the needs of the seriously injured, while hopefully reducing the number of law suits. The patient would still retain the right to sue, but payments made under the AMA plan would be deducted from the final verdict if he won.

The House also voted "that workshops on malpractice insurance problems be conducted as requested by the Board of Trustees, in which participation will be invited from physicians confronted by insurance problems, representatives of the insurance carriers, staff attorneys of AMA and other appropriate staff personnel, representatives of and attorneys for the hospital service field, nurses and legislators." At the same time, the House voted against the establishment of a nationwide professional liability insurance program because of difficulties

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which would be encountered by the many different insurance laws in the 54 states and territories.

Many efforts have been made to stem the tide of mounting malpractice suits. Dr. Carl Bearse, Chairman of the Committee on Professional Liability of the MMS, points to two provisions concerning malpractice suits in Canada and other countries which would in the opinion of the Committee be most helpful to physicians if they could be adopted in this country: (1) the losing party in litigation must pay the court and legal fees of the defendant physician, and (2) contingency fees for lawyers are banned except for court-determined indigent clients.

The same MMS Committee furthermore refers to legislation introduced in Michigan requiring the plaintiff in a malpractice action to post a bond which he would forfeit if he lost and the bond would be paid to the accused physician.

Compulsory arbitration that would be binding to both sides, might well reduce law suits if a workable plan could be agreed upon. The Ross-Loos Group is a prepaid medical group practice in California. Since 1950 this group has required that patients must submit all malpractice claims to arbitration. The panel hearing the dispute is generally made up of a lawyer chosen by each side, plus a third judge or lawyer agreed upon by both sides. While the plan has successfully reduced suits and in addition the plan has the additional merits of avoiding publicity and speeding up disposition of cases, there nevertheless remains the question as to whether it would work in private practice. The courts thus far have upheld the arbitration clause in the Ross-Loos Group contract because it is a prepayment plan. Bernard Hirsh, General Counsel to the AMA, raises doubts that binding arbitration would be upheld by the courts in private practice, and he feels that this is not the answer to the problem.

To cut down on "nuisance suits" the California Medical Association is trying to get the legislature to require the plaintiffs to post a bond of $500 for court costs, hoping to eliminate unjustified suits. Furthermore, the CMA is trying to modify the state statute of limitations which the courts have interpreted as running for one year after the patient discovers his injury. Accordingly, a doctor is vulnerable for law suits as long as he lives, and insurance carriers are uncertain of their status for many years after writing or renewing a malpractice policy. The CMA wants the statute of limitations to start with the date of the alleged injury or discontinuation of treatment "except upon proof of fraud or intentional concealment" by the doctor.

Physician-lawyer screening panels to decide on the justification of a suit is another method of combatting the rising tide of malpractice claims. Dr. Carl Bearse, Chairman of the Committee on Professional Liability of the MMS, reports that as of 1962 forty-two states had physician-lawyer screening panels. However, unfavorable decisions did not stop the plaintiff from filing suit, and many of these panels have been abandoned. Nevertheless, successful panels have operated in Arizona, New Mexico, New Jersey and parts of Nevada. In New Jersey, a court-appointed panel consisting of two physicians and two lawyers with a judge as chairman has been in operation for two years, and the New Jersey Medical Society has been pleased with the results. Nevertheless, sharp increases in insurance rates have continued in that state.

A more successful screening panel has been the so-called "Tucson Plan" (Arizona) which has operated with a certain measure of success for the past

twelve years. Thus far it appears that patients, lawyers and physicians have seemed satisfied with the results. In this plan, a panel of an equal number of physicians and lawyers meets in secret session to determine whether there is substantial evidence of malpractice and whether there is a likely possibility that the patient was injured as a result thereof. If the panel decides in the affirmative, the defendant physician is advised to settle the claim or risk a law suit in which the panel will provide medical witnesses for the plaintiff. So far, only one physician, an orthopedist, refused to accept the panel's advice and went to court. He lost and the patient was awarded $47,000 by the jury. Of 57 plaintiffs whose claims were decided against them by the panel, only three went to court against the panel's advice, and all three lost in court. The screening out of unjustified suits by the panel is a notable virtue of this plan. "It is the filing of a suit and the publicity that goes with it that is often the most damaging aspect to the physician," says Dr. I. M. Chesser, who serves as panel co-chairman together with a bar association officer. Dr. Chesser believes that physicians found negligent are more willing to accept the panel's decision than that of a jury. The plan rotates one or two doctors on the panel annually so that both professions work together in judging physicians. The lawyers are there to ask questions if any of the physician members might be tempted to favor a colleague without justification.

SELF POLICING

In the last analysis, elimination of malpractice suits requires elimination of justification for such suits. Even then, there will always be patients who will bring suit without adequate basis, but a baseless suit has little appeal to an experienced lawyer. It is up to us, therefore, to practice the best medicine that we can, obviously for the sake of good medical care for our patients, but also for our own good to prevent law suits. The Third National Medical-Legal Symposium jointly sponsored by the AMA and the American Bar Association in March, 1969 cited the types of medical negligence which may lead to law suits: poor records, lack of consultations, blood matching errors, illegible writing of orders, and what is called the "busy doctor syndrome," meaning inadequate attention to detail because of the pressure of work.

Self-policing of the medical profession is necessary to weed out incompetents, careless practitioners, poorly trained or inadequately trained physicians, alcoholics, drug addicts, and many others who contribute to rising malpractice insurance rates. Hospital staffs are probably the most effective groups in policing medical practice by withholding hospital privileges to those who do not meet their standards. Organized medicine has made a good start. The AMA is beginning to issue certificates for post-graduate education and the American Academy of General Practice has for some time required continuing post-graduate education for membership. The various specialty societies have also encouraged post-graduate education through their requirements for various categories of membership. Yet, there remains much to be done before all incompetents are removed, and until this is accomplished, the problem of malpractice will be with us. **Tillman**

IN MEMORIAM

STEPHEN A. MAHONEY, JR., M.D.

1900 - 1969

Dr. Stephen A. Mahoney, Jr., of 201 Madison Ave., Holyoke, died at the Holyoke Hospital on November 27, 1969.

Born in Holyoke, Mass., on March 1, 1900, Dr. Mahoney attended local schools, graduated from Harvard College in 1921, and received his doctorate in medicine from Harvard Medical School in 1924. Upon completion of his internship and residencies at the Mass. General Hospital, the Children's Hospital, the Boston Lying-In Hospital, and the Good Samaritan Hospital, all in Boston, he returned to his native Holyoke in 1927, where he entered into private practice with major concentration in surgery.

Dr. Mahoney served on the medical staffs of Providence and Holyoke Hospitals for many years. He was a fellow of the American College of Surgeons and a member of many national professional organizations including the AMA, the Radiological Society of North America, the American Society of Abdominal Surgery, the American Society of Clinical Hypnosis. He was also a member of the MMS and HDMS. Dr. Mahoney was also a dedicated civic and business leader in his community.

To his family, his friends, and associates deepest sympathy is hereby extended.

IN MEMORIAM

RICHARD V. PAUL, M.D.

1930 - 1969

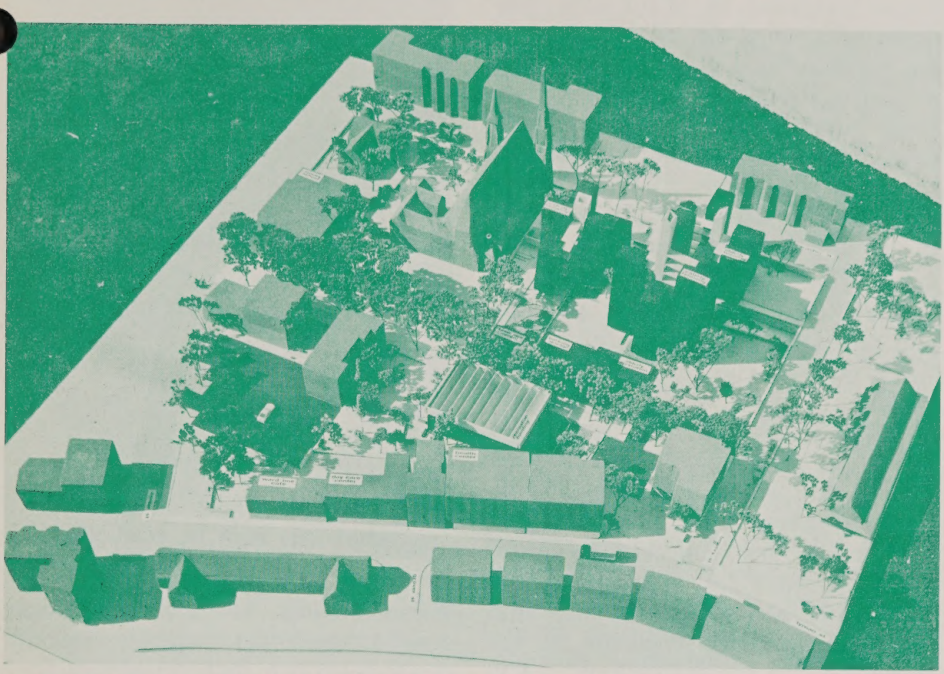
Dr. Richard V. Paul of 85 Shady Side Drive, Longmeadow, died at Peter Bent Brigham Hospital, Boston, on December 11, 1969.

Born in Springfield, Massachusetts, on October 11, 1930, Dr. Paul attended local schools including American International College and received his doctorate in medicine from Tufts University Medical School in 1957. After serving his internship and residency at the St. Elizabeth's Hospital in Boston, he returned in 1960 to his native Springfield, where he engaged in the practice of anesthesiology until his demise.

Dr. Paul served on the medical staffs of the Mercy and Wesson Memorial Hospitals. He was a member of the American Society of Anesthesiologists, the American Medical Association, the Massachusetts Society of Anesthesiologists, the MMS and the HDMS.

Deepest sympathy is hereby extended to his family, and to his many friends and associates.

HOLYOKE'S MODEL CITIES' HEALTH CARE PROGRAM



Scale model section of the neighborhood in Holyoke's Model Cities Area which will hopefully contain the new neighborhood services center including a health center, which is the square building in the middle of the second row from the bottom.

In the forthcoming year, Holyoke's Ward One, the Model Cities Area, will be involved in the development of new approaches to the delivery of medical care. The health project of the Model Cities' program is almost completed and is waiting final funding, which is anticipated in April, 1970.

DEMOGRAPHY

The Ward One area of Holyoke is located in the northeast section of the City bordering the Connecticut River and contains many manufacturing firms. It is a low income area in which 13.5% of the families are receiving some form of welfare assistance. The total population is 4,700 of which 38% are French, 21% Puerto Rican, and 16% Negro. Forty-seven percent of the residents are under 20, and 13% are over 60. None of Holyoke's 61 practicing physicians has an office in the Ward, and the nearest hospital is about one and a half miles away.

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CLINIC

During the past year, a health task force, composed of Ward One residents who were elected members of the neighborhood council and health professionals—doctors, dentists, hospital administrators, mental health psychologists, visiting nurses, and personnel of the Mass. Health Department—have tried to analyze the needs of the area and have drawn up a plan to see if these health needs can be met.

The Model Cities' health program will be centered around a health clinic which will be housed in a renovated building. A physician is scheduled to attend the clinic daily, and as the need arises, his services will be called on more. There will be a permanent public health nurse at the clinic who will have under her supervision several neighborhood aides. It is hoped that the neighborhood aides will come into close contact with residents of the Ward. By "on site inspections," these aides will be aware of problems like poor sanitation or inadequate food supplies which can be brought to the attention of the public health workers.

It is hoped that paramedical people will take over much of the operations of the neighborhood clinic and refer those cases requiring diagnostic work-ups to the appropriate physicians in the City. On the one hand, the neighborhood clinic will save the already overburdened practitioner's time by caring for minor problems which don't require his attention. On the other hand, the ready availability of medical care may reveal undiagnosed medical problems which will require the physician's diagnostic skills. Theoretically, these new patients will be treated for preventable diseases which are less time consuming and more rewarding to treat than the caring of illness in its end stages.

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LASTING EFFORT?

The Model Cities' Health Project will be funded initially by HUD-Housing and Urban Development—through a Neighborhood Facility Grant, and also by funds from HEW-Health Education and Welfare—via Demonstration Health Service Programs and Dental Demonstration grants. Since Model Cities' programs are only funded by the federal government for approximately a five year period, plans are being made to make the program self sustaining.

At the suggestion of PMI-the Post Graduate Medical Institute—which has worked with hospital staffs involved in community health in the depressed sections of cities, namely, Providence, R. I. and Lowell, Mass., a joint committee on community health has been set up by the Providence and Holyoke Hospitals. The functions of the Committee on Community Health will be to work in cooperation with the Model Cities' clinic to implement its delivery of medical care. Hospital staff members can lend their medical expertise to the functioning and improvement of the health clinic. Also, the hospitals can offer supplementary help in the fields of nursing, laboratories, administration, etc.

Many health projects in the past decade have been of questionable success. In the Watts section of Los Angeles, where new health centers have been set up, it is reported that there has been no significant decline in diseases. However, the one variable in depressed areas which seems to correlate with improved health is that of improved housing. But, the hard fact remains that people in depressed areas are not getting the medical care they need whether it be due to a failure of communications in knowing what is available and how to obtain it, or to unavailability of medical care.

Whether the Ward One Model Cities' Health Care Program in Holyoke is going to be an ongoing venture and serve as a model for other health units in the City, rather than a transient showpiece, is dependent on many complex social variables; but it behooves the medical profession to offer its "know how" and leadership in an attempt to upgrade the health of the depressed areas of the city.

The potential role that the present day physician might play in the health care of the depressed areas was succinctly summed up by the famous German pathologist, Rudolph Virchow, 120 years ago when he wrote: "Medicine has imperceptibly led us into a position to deal with great social problems of our time. Doctors are the natural advocates of the poor, and social problems are very largely within their jurisdiction."

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HIGHLIGHTS OF THE NOVEMBER EXECUTIVE COMMITTEE MEETING

The Executive Committee met on November 18, 1969, in the Conference Room of the HDMS. Dr. Mozden called the meeting to order at 8:10 P.M. Present were Drs. Mozden, Stoler, Collard, Anton, Sullivan, Barnes, Moore, Kelly, Boivin and Mrs. Purdy.

Minutes of the October meeting were read by Dr. Stoler and accepted as read.

CORRESPONDENCE

A letter from Mr. King, Deputy of the Model Cities' Agency was read. This has been answered with reservations. Dr. Sheffield is HDMS representative to Model Cities.

A letter from the Police Chief of Westfield thanking Dr. Booker for his fine presentation to new police on emergency childbirth was read. A copy has been sent to Dr. Booker and a letter of thanks will be written to Chief Donald.

Dr. Stare as a representative of the Massachusetts Citizens Committee for Dental Health has asked for a local representative to serve on a state level promoting fluoridation of water supplies in Massachusetts. This has been referred to Dr. Sears for a suggested name.

Dr. Wecker, a member from Winchendon, wrote informing the Society that he will be moving to New York State. Dr. Stoler will write Dr. Wecker about the proper procedure for transferring.

COMMITTEE REPORTS

Dr. D'Avanzo sent a report of the Hospital-Physician Relations Committee. It was read and approved by the Committee to have it printed in *The Hampden Hippocrat* and then to be presented at the February District meeting for membership discussion.

Dr. Beachman, Chairman of the Tax Supported Medical Care Committee, sent the following report as a result of a recent meeting in Boston. "The Massachusetts Medical Society Committee on Tax Supported Medical Care met in Boston, November 12, 1969. There is some good news to report:

1. The new forms that were to go

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into effect October 1, 1969 and then delayed, are no longer valid. (Please, save them though, so that you can return them when you receive the new modified forms.) 2. The modified form will be the only form that has to be filled out. Also, you can continue to use your own personal prescription forms. 3. The fee situation has not been settled as yet. Negotiations on this should be started shortly."

OLD BUSINESS

Three resolutions submitted by Dr. James Allan at the September District meeting were discussed. The Committee voted unanimously that they be approved and sent to the Secretary of the MMS.

Dr. Davis, Chairman of the Blood Bank Committee, requested permission to set up rosters with the four Springfield hospitals for coverage of bloodmobiles. The Committee endorsed his request.

As no answer had come as yet from the Ethics & Discipline Committee of the MMS about the Massachusetts General Hospital, this matter was tabled until the December meeting.

The Committee voted to send Dr. Ernst's recommendations regarding nursing homes to the MMS with the Executive Committee's endorsement.

NEW BUSINESS

A letter from Medical Association Planners, Ltd., Inc. was considered. It was thought that a special meeting planned and held at the Springfield Municipal Hospital Auditorium would be informative to members interested in incorporating. Such a meeting will be planned for January.

"Physicians Guide to Air Pollution" will be mailed with the next *Newsletter* and will be supplied by the Hampden-Berkshire Tuberculosis and Respiratory Disease Association.

The meeting adjourned at 10:40 P.M.

The Grievance Committee met and heard two cases. Letters will be sent to persons concerned.

The Grievance Committee adjourned at 11:45 P.M.

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HDMS NOVEMBER

Our Leaders L. to R.: Dr. Gerald D. Dorman, President of the AMA, and Dr. Walter S. Mozden, President of the HDMS.

The November meeting of the HDMS was held at the Highpoint Motor Inn, Chicopee, on the twenty-fifth of November with 189 physicians and their wives from Hampden, Hampshire, Franklin, and Berkshire District Societies in attendance. After a warming social hour and a sumptuous dinner Dr. Mozden called the meeting to order and introduced the dignitaries at the head table as well as the guests from the neighboring district societies.

The piece de resistance was then served up in the person of Gerald D. Dorman, M.D., President of the AMA. After the usual pleasantries and cordialities, Dr. Dorman launched into his talk by raising the question as to whether the AMA is an organization dying of old age. In his opinion, the AMA is an ongoing body, but it "needs a new infusion of young blood into it along with the blood of those who are our colleagues but not in the organization." He then went on to speak about his recent experiences with medical students. A point was made that these students were "going to carry on" in the profession "no matter what we think of them." Hence, it is "high time that we had them working with us so that they can take over the duties that we have carried." Dr. Dorman mentioned the case of the Colorado Medical Society, wherein a separate district was created solely for medical student membership with full voice and vote in the Society's affairs. The case of SAMA, wherein 2 members of that organization are elected to full membership in the House of Delegates of AMA, was also mentioned. Moreover, delegates from SAMA now sit with various councils and committees of the AMA. All this is leading to a better understanding that the AMA is a progressive organization intent on arriving at practical solutions to problems facing medicine today. Admittedly the AMA has failed to get "the message" to the students and nonmem-

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ber physician colleagues, but progress is being made in this direction.

Dr. Dorman spoke of the quality of medical care across the country and the problem of continuing medical education for all physicians because of the explosion of new medical knowledge. Admittedly as time goes on from whence a physician graduates from medical school, he has progressively less applicable knowledge if he does not keep up his medical education. Hence, it is an obligation for each physician to do so. To encourage this, the AMA has initiated the Award on Continuing Education program. This has received "plaudits" and "brick bats," but it is a step in the right direction. Periodic relicensing statutes seem to be a harsh measure for hard-working physicians, who for the most part are making every effort to keep up with new developments in medicine. In spite of various detrac-

With Our Neighbors L. to R.: Dr. Dorman, Mrs. Dorman, Dr. Robert W. Gage, President of the Hampshire District Medical Society, and Mrs. Gage.

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tors and doctor baiters, physicians are doing a good job throughout the country.

Dr. Dorman then went on to discuss medical care systems and stated that no controlled program can come from Washington or Chicago. "The problems of medical care are local problems in each area, and the people best able to decide what resources there are available to take care of their patient load is the responsibility of the local medical organization and the local physicians in that area." "These are the doctors that we depend on; these are the doctors that we look to carry on."

Mention was also made of the need of support from professions allied to medicine—not only support, but also use and control so as to prevent the allied professionals from exceeding their capabilities. Proper training and use can certainly increase physicians' productivity without compromising quality. There is indeed a physician shortage today, but it is greatly aggravated by a sophisticated public expecting more and more miracles.

Dr. Dorman spoke of the physician as a citizen and the need for him to get involved in and to give leadership in such community problems as housing, pollution, malnutrition, population control, and public health education with appropriate group support. Mention was made of the AMA's continuing and planned increased involvement in these areas.

After the conclusion of Dr. Dorman's presentation, there followed a brief question and answer period with the meeting being adjourned at 9:50 P.M.

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Dr. James Smith spoke on "The Emotional Needs of Your Children" at the Frederick Harris School PTA.

Dr. James Collins spoke on "Health Care Utilization" at a seminar held by Blue Cross in Boston.

Mrs. Purdy was named President of the Visiting Nurse Association.

Dr. Kennedy was named Chairman of the Nominating Committee for next year at the V.N.A. Also serving on the Professional Advisory Committee are Drs. Sanderson, Plotkin, and Natale.

Dr. Field Leonard introduced Dr. Dorman, President of the AMA, at the Kiwanis Meeting, where Dr. Dorman was the guest speaker.

Dr. Myra Sheyevitz was initiated a fellow of the American College of Chest Physicians recently in Chicago.

Dr. Wakefield attended a meeting of the American College of Physicians at the University of Michigan on "Nuclear Medicine."

Dr. Suzor spoke to the Mercy Guild on "Drug Abuse."

Dr. Kendrew received a standing ovation from the audience at the Elms College three day seminar on drugs.

Dr. Hough spoke to the Longmeadow Senior class, to the Kodimoh Synagogue and to Kiwanis Club of Springfield on "Drug Abuse."

Dr. Zadworny spoke to the Western Massachusetts Public Health Association and Boards of Health on "VD."

Dr. LaMarche spoke to the Kiwanis Club of West Springfield on "Drug Abuse."

Dr. Janes represented the HDMS at the Longmeadow High School meeting on Drug Abuse.

Dr. Keitlen spoke to Mt. Carmel Guild on "Sex Education."

Dr. Romanos, a new member, spoke to the Order of the Golden Chain on "Drug Abuse."

Dr. Shuman spoke on "New intensive care unit at Wesson Maternity" to the Auxiliary.

THE NEXT MEETING OF THE SPRINGFIELD ACADEMY OF MEDICINE

will be held on

Tuesday, January 13, 1970, at 8:30 P.M.

SPEAKER: Sidney S. Gellis, M.D.
Pediatrician-in-Chief
New England Medical Center Hospital

TOPIC: "Use of Light and Drugs in the Treatment of Jaundice"

CLINIC: Springfield Hospital Medical Center, 5:00 P.M.

CORRESPONDENCE

HOSPITAL-PHYSICIAN RELATIONSHIPS

To the Editor:

At the annual meeting of the District Medical Society in April, 1969, the members present voted for the formation of a special committee on physician-hospital relationships. Subsequently, this committee was appointed consisting of Doctors Anton, Douglas, Sullivan, McHugh, Mosig, Prybylo, and myself as chairman.

The function of this committee is mainly informational and it was decided to limit the scope at present to three facets, namely:

1. The increasing practice of hospitals to employ physicians on an annual salaried basis and to keep the entire fees for the physicians' services. 2. The protection of the physician members by the Medical Society. 3. The adequate representation of the medical staff on the board of trustees of hospitals.

The June, 1964 official report of the A.M.A. on Physician-Hospital Relations stated: "It is the firm policy of the A.M.A. that only a licensed doctor of medicine should practice medicine. It is not in the public or professional interest for a third party to derive a profit from payment received for medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship." This policy is the official A.M.A. policy to the present day. In the same report it was stated that Massachusetts has the highest percentage of salaried physicians of all the states.

In reply to a letter from our committee to the A.M.A., Roger G. Olin, Associate Director of the Department of Community Heatlh, stated that, "The usual concept is that when not-for-profit corporations employ physicians and collect and keep the professional fees, they are engaged in the corporate practice of medicine."

In reply to a letter from our committee to the Massachusetts Medical Society, Everett R. Spencer, Jr., the Executive Secretary, stated that, "Legal advice is, in essence, that if a hospital employs physicians on an annual salary basis and receives and keeps the fees of the services of these physicians, it is practicing medicine."

This practice is no longer confined to the Boston area with its high concentration of medical schools and associated hospitals, but is spreading to every city and town throughout Massachusetts.

The second facet that the Committee considered was the protection of the physician members by the Medical Society. Many of the members believe that this protection has been far from adequate, particularly in the area of physician-hospital relationships. Any physician's staff appointment at the private hospital can be terminated at any time. The private

Ernest A. Byron

* * *

SPRINGFIELD

* * *

practicing physician is the very backbone of the Medical Society and should receive the Society's adequate protection. He should not be left to do battle alone against the large hospital corporation when he has a just grievance concerning his hospital privileges. More and more, the physician's hospital staff appointment is vital to his financial security and too often, the individual physician will back down even though his cause is just, in order to safeguard his livelihood.

The third and last facet our committee considered is the representation of the medical staff on the board of trustees. In most hospitals, this representation is far from adequate. This policy must change. The medical staff needs adequate representation for proper communication and also to help formulate policies that affect every physician member of the staff. In order to serve our community more effectively, there should be no barriers between the board of trustees and the medical staff. Instead, there should be a constant flow and exchange of information and ideas.

I urge every member of the Medical Society to attend the February 3rd meeting at Storrowton. The issues raised by this report will be fully discussed at this meeting. Please, come! We need your participation and support.

Charles S. D'Avanzo, M.D.
Chairman, Committee on
Hospital-Physicians
Relations

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To the Editor:

Periodically and particularly during the so-called vacation seasons, patients are being referred to the Commissioner of Public Health of Springfield for the making out of death certificates on patients in the City of Springfield who have died while their personal physician was out of town. Usually the first approach is to the Medical Examiner, who, when he feels the case is not within his province, declines to accept the responsibility. Then the approach is made to the Commissioner of Public Health. The latter approach is based on a statement on the back of the Standard Certificate of Death of the Commonwealth of Massachusetts, which comes under Rules of Practice:

(1) Attending physicians will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) Board of Health physicians will certify to such deaths only as those of persons, who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

Although these general rules are very succinct in their statements, it must be recognized that attending physicians have certain obligations which they cannot slough off on to some public official for their own comfort and convenience. Should an attending physician find himself in the position that he expects to be out-of-town for a period of time, then it first behooves him to arrange for some other physician to take care of his patients during this period of time. Secondly, the covering physician assumes completely the responsibilities of the attending physician during this period of time when the primary physician is unavailable. Otherwise, there exists a situation tantamount to the abandonment of a patient.

In the instance of death of a patient, the pronouncement of death is a diagnostic procedure and therefore is considered the practice of medicine. Inasmuch as a covering physician assumes the responsibilities of the original attending physician, then it behooves the former to make the diagnosis and sign the death certificate.

The intent of the rule (2) as quoted above is to take care of emergency situations where there is no possibility of obtaining a death certificate, and it is urgent to dispose of the body properly. The intent certainly is not to grant automatic "carte blanche" coverage to any attending physician to go out of town at any time with the expectation that a Board of Health physician will cover him in any instance of death to one of his patients. Moreover, the intent of the rule is not to grant automatic absolution of responsibility to the covering physician for the care, pronouncement of death, and signing of a death certificate.

A covering physician who is unwilling to accept the responsibilities of the attending physician in absentia could be considered culpable of a breech of medical ethics.

Sincerely yours,

John C. Ayres, M.D.
Commissioner of Public Health

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HDMS MEETING, FEBRUARY 3
HDMS EXECUTIVE COMMITTEE MEETING, JANUARY 20 and FEBRUARY 17
MMS COUNCIL MEETING, BOSTON, FEBRUARY 11
MMS ANNUAL MEETING, BOSTON, MAY 26-28
SOCIETY OF THORACIC SURGEONS, ATLANTA, JANUARY 11-14
AMERICAN SOCIETY FOR SURGERY OF THE HAND, CHICAGO, JANUARY 16-17
AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS, CHICAGO, JANUARY 17-22
AMA ANNUAL MEETING, CHICAGO, JUNE 21-25

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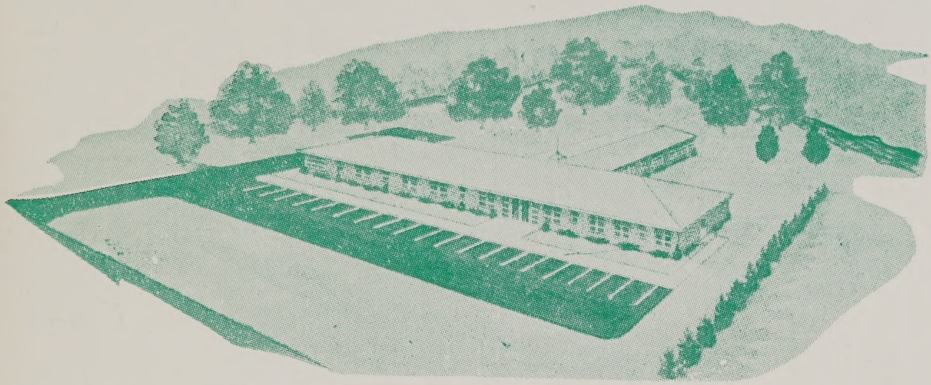

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